MUNICIPAL PLAN COMPARISON TEMPLATE (AS OF JULY 1, 2008)

HMO Options For Employees and Non-Medicare Retirees & Survivors

Plan Design Feature	Municipal HMO Plan	*Group Insurance Commission Plans*			
		Fallon Select Care	**Fallon Direct Care**	**Neighborhood Health Plan (NHP Care)**	**Health New England**
Network		**Large Network HMO**	**Limited Network HMO**	**Large Network HMO**	**Large Network HMO**
Coverage Area					
Not Available In These Counties		Barnstable, Dukes, Franklin or Nantucket	Barnstable, Berkshire, Bristol, Dukes, Franklin, Plymouth and Nantucket	Berkshire, Barnstable, Dukes, Franklin, Hampshire and Nantucket	Barnstable, Bristol, Dukes, Essex, Middlesex, Nantucket, Norfolk, Plymouth and Suffolk
Key Cost Features					
Monthly Premium					
Individual		$471.68	$397.47	$421.74	$427.06
Family		$1,132.03	$953.91	$1,117.61	$1,058.70
Calendar Year Deductible					
Individual		None	None	None	None
Family		None	None	None	None
Out-of-Pocket Maximum					
Individual		None	None	None	None
Family		None	None	None	None
Lifetime Maximum					
Individual		None	None	None	None
Family		None	None	None	None
Services Provided In A Physician's Office					
Primary Care Physician Office Visit					
Tier 1 **"Excellent"**		$10 copay	$10 copay	$10 copay	$10 copay
Tier 2 **"Good"**		$15 copay	No tiering	$20 copay	$15 copay
Tier 3 **"Standard"**		$25 copay	No tiering	$25 copay	$25 copay
Specialist Office Visit					
Tier 1		$15 copay	$15 copay	$15 copay	$15 copay
Tier 2		$25 copay	No tiering	$25 copay	$25 copay
Tier 3		$35 copay	No tiering	$35 copay	$35 copay
Services Provided In A Hospital Setting					
Emergency Room		$75 copay	$75 copay	$75 copay	$50 copay
Waived, if admitted?		Yes	Yes	Yes	Yes
Per Admission					
Tier 1		$250 copay	$200 copay	$250 copay	$250 copay
Tier 2		No tiering	No tiering	No tiering	No tiering
Tier 3		No tiering	No tiering	No tiering	No tiering
Limits on number of copays		Maximum of four copays per calendar year; waived if readmitted within 30 days of discharge	Maximum of four copays per calendar year; waived if readmitted within 30 days of discharge	Maximum of four copays per calendar year; waived if readmitted within 30 days of discharge	Maximum of four copays per calendar year; waived if readmitted within 30 days of discharge

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		Fallon Select Care	**Fallon Direct Care**	**Neighborhood Health Plan (NHP Care)**	**Health New England**
Outpatient Surgery		$125 copay	$100 copay	$100 copay	$100 copay
Limits on number of copays		Maximum of four copays per calendar year	Maximum of four copays per calendar year	Maximum of four copays per calendar year	Maximum of four copays per calendar year
Diagnostic X-Ray and Lab Service		No copay	No copay	No copay	$50 copay for advanced diagnostic imaging services (MRI, PET Scan); No copay for X-Rays
Rehabilitation Hospital		$250 per admission	$200 per admission	$250 per admission	$200 per admission
Benefit Limits		Up to 100 days per year	Up to 100 days per year	Up to 100 days per year	Up to 100 days per year
Skilled Nursing Facility		No copay	No copay	No copay	No copay
Benefit Limits		Up to 100 days per year	Up to 100 days per year	Up to 100 days per year	Up to 100 days per year
Physical Therapy, Occupational Therapy & Chiropractic Treatment					
Physical Therapy					
Tier 1		$15 copay	$10 copay	$10 copay	$15 copay
Tier 2		$20 copay	N/A	$20 copay	N/A
Benefit Limits		Unlimited visits within 90 calendar-days following injury/illness	Unlimited visits within 90 calendar-days following injury/illness	Unlimited visits within 90 calendar-days following injury/illness	Unlimited visits within 90 calendar-days following injury/illness
Occupational Therapy					
Tier 1		$15 copay	$10 copay	$10 copay	$15 copay
Tier 2		$20 copay	No tiering	$20 copay	No tiering
Benefit Limits		Unlimited visits for up to 90 days following injury or illness	Unlimited visits for up to 90 days following injury or illness	Unlimited visits for up to 90 days following injury or illness	Unlimited visits for up to 90 days following injury or illness
Chiropractic Services					
Tier 1		$15 copay	$10 copay	Not covered	Not covered
Tier 2		$20 copay	No tiering	Not covered	Not covered
Benefit Limits		20 visits per year, for acute musculo-skeletal conditions; Member's Primary Care Physician will provide a referral to a network chiropractor for up to five additional visits, if medically necessary; Chiropractor must obtain pre-authorization from Fallon for all subsequent visits	20 visits per year, for acute musculo-skeletal conditions; Member's Primary Care Physician will provide a referral to a network chiropractor for up to five additional visits, if medically necessary; Chiropractor must obtain pre-authorization from Fallon for all subsequent visits	No benefit provided	No benefit provided

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Mental Health Services					
In-patient treatment; biologically-based illness		No copay	No copay	No copay	No copay
Benefit Limits		Unlimited number of days	Unlimited number of days	Unlimited number of days	Unlimited number of days
Out-patient treatment; biologically-based illness					
Tier 1		$15 copay	$10 copay	$10 copay	$15 copay
Tier 2		$20 copay	No tiering	No tiering	No tiering
Benefit Limits		Unlimited visits	Unlimited visits	Unlimited visits	Unlimited visits
Pharmacy Services					
Retail Copay (up to 30 day supply)					
Tier 1		$10	$10	$10	$10
Tier 2		$25	$25	$25	$20
Tier 3		$40	$40	$45	$40
Mail order Copay (up to 90 day supply)					
Tier 1		$20	$20	$20	$20
Tier 2		$50	$50	$50	$40
Tier 3		$90	$90	$135	$120
Separate pharmacy deductibles.		No	No	No	No
Does this plan include or require any unique pharmacy management features (mandatory use of generics, step therapies, mandatory specialty drug program)?		Certain drugs in the formulary are covered only when determined to be medically necessary; Coverage for any drug not listed in the formulary requires prior authorization	Certain drugs in the formulary are covered only when determined to be medically necessary; Coverage for any drug not listed in the formulary requires prior authorization	Generic substitution is mandatory whenever possible; Select over-the-counter cough, cold, and allergy medications are covered with a valid prescription from a participating provider	Utilizes a step therapy program; prior authorization required for certain drugs
Additional Services					
Does plan cover infertility services?		Yes	Yes	Yes.	Yes.
Are their any frequency limitations on infertility services?		Approval for assisted reproductive technology (ART) is contingent upon medical director review; Original approval is for four (4) ART cycles; Assistance beyond four cycles is contingent upon further review by carrier's medical director	Approval for assisted reproductive technology (ART) is contingent upon medical director review; Original approval is for four (4) ART cycles; Assistance beyond four cycles is contingent upon further review by carrier's medical director	Covers medically necessary expenses for the diagnosis and non-experimental treatment of infertility to the same extent that benefits are provided for other medically necessary services and prescription medications	Covers all non-experimental infertility procedures subject to the carriers review and approval submitted by a members primary care physician; Infertility services are subject to specific limits and exclusions in accordance with the carrier's Infertility Protocol which is available from the carrier

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Additional Services Continued Does plan cover other reproductive services including birth control and abortion services?		Yes	Yes	Yes	Yes
Routine Vision Care Does plan cover vision exams?		Yes	Yes	Yes	Yes
Frequency of vision exams		Once every 24 months.	Once every 24 months.	Once every 24 months.	Once every 24 months.
Copay for a vision exam. **Hearing Aids** Does the plan cover hearing aids?		$15 Yes	$10 Yes	$10/$20/$25 [based on tier of PCP] Yes	$15 Yes
Hearing aid benefit		Member pays 0% of the first $500 and 20% of the next $1,500; benefit available once every two years	Member pays 0% of the first $500 and 20% of the next $1,500; benefit available once every two years	Member pays 0% of the first $500 and 20% of the next $1,500; benefit available once every two years	Member pays 0% of the first $500 and 20% of the next $1,500; benefit available once every two years
Ambulance Service Copay		No copay	No copay	No copay	No copay
Gym Membership Benefit		$150 per individual per year, $300 per family per year	$150 per individual per year, $300 per family per year	None	$150 per family per year

The information contained in this spreadsheet is for illustrative purposes only and based on publicly available information. The detailed plan design information for the Group Insurance Commission (GIC) plans and/or the municipal plan(s) has not been approved by either the GIC or the GIC's insurance carriers or by the municipality or the municipality's insurance carriers. With respect to the GIC benefits shown, complete information about specific benefits is contained in the "Summary Plan Descriptions" (known as the GIC's health plans' "Plan Handbooks") for each program, which are available from the GIC. More detailed information about a municipality's plan may be obtained from the municipality. Boston Benefit Partners, LLC does not represent or warrant that the information provided herein specifically reflects any program.